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No. 80-1594

In the Supreme Court of the United States

OCTOBER TERM, 1980

UNITED STATES OF AMERICA, PETITIONER

v.

ERIKA, INC.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS

BRIEF FOR THE PETITIONER

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QUESTION PRESENTED

Whether the Court of Claims has jurisdiction under 28 U.S.C. (& Supp. III) 1491 to review determinations by private insurance carriers of the amount of benefits payable under Part B of the Medicare Act, 42 U.S.C. (& Supp. III) 1395j *et seq.*

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BRIEF FOR THE PETITIONER

OPINION BELOW

The opinion of the Court of Claims (Pet. App. 1a-28a) is reported at 634 F.2d 580. The decisions of the insurance carrier's hearing officer (Pet. App. 34a-88a) are unreported.

JURISDICTION

The opinion of the Court of Claims was issued on October 22, 1980. An order removing the case from the Court of Claims' docket (Pet. App. 29a) was entered on October 24, 1980. The Court of Claims' order on the government's motion for rehearing, clarifying certain aspects of the court's opinion (Pet. App. 30a-33a), was

entered on February 6, 1981. On January 12, 1981, the Chief Justice extended the time for filing a petition for a writ of certiorari to and including March 21, 1981. The petition was filed on March 20, 1981, and was granted on May 18, 1981. The jurisdiction of this Court rests on 28 U.S.C. 1255(1).

STATUTORY PROVISIONS INVOLVED

1. 28 U.S.C. (& Supp. III) 1491 (the Tucker Act) provides in pertinent part:

> The Court of Claims shall have jurisdiction to render judgment upon any claim against the United States founded either upon the Constitution, or any Act of Congress, or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort. * * * To provide an entire remedy and to complete the relief afforded by the judgment, the court may, as an incident of and collateral to any such judgment, issue orders directing restoration to office or position, placement in appropriate duty or retirement status, and correction of applicable records, and such orders may be issued to any appropriate official of the United States. In any case within its jurisdiction, the court shall have the power to remand appropriate matters to any administrative or executive body or official with such direction as it may deem proper and just. * * *

2. Section 205(h) of the Social Security Act, incorporated into the Medicare Act through 42 U.S.C. 1395ii and codified at 42 U.S.C. (1970 ed.) 405(h), provides:

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any

person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of title 28 to recover on any claim arising under this subchapter.[*]

3. Section 1842 of the Social Security Act, 42 U.S.C. 1395u(b)(3)(C), states that each contract between the Secretary and a carrier must provide that the carrier

> (C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more, when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

4. Section 1869 of the Social Security Act, 42 U.S.C. 1395ff, provides in pertinent part:

> (a) Entitlement to and amount of benefits.
>
> The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A, shall be made by the Secretary in accordance with regulations prescribed by him.
>
> (b) Appeal by individuals.
>
> (1) Any individual dissatisfied with any determination under subsection (a) of this section as to—
>
> (A) whether he meets the conditions of section 426 or section 426a of this title, or
>
> (B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this subchapter, or section 1395i-2 of this title, or section 1819, or

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* In the 1976 edition of the United States Code, which has not been enacted into positive law, the third sentence of Section 205(h) is changed to refer to "sections 1331 and 1346" of Title 28 rather than "section 41 of title 28," as in the Social Security Act itself.

(C) the amount of benefits under part A (including a determination where such amount is determined to be zero)

shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

STATEMENT

Respondent brought this action in the United States Court of Claims seeking increased reimbursements for medical supplies that it sold to persons who were insured under Part B of the Health Insurance for the Aged and Disabled Act (Title XVIII of the Social Security Act, 42 U.S.C. (& Supp. III) 1395 *et seq.*), commonly known as the Medicare Act. Those customers of respondent had assigned thousands of their individual reimbursement claims to respondent for collection under the Medicare program. The only question presented in this Court is whether the Court of Claims had jurisdiction under 28 U.S.C. (& Supp. III) 1491 to entertain respondent's action.

1.*a.* The Medicare Program is divided into two parts. Part A of the Act (42 U.S.C. (& Supp. III) 1395c to 1395i-2) provides insurance for hospital and related post-hospital services. 42 U.S.C. (& Supp. III) 1395c and 1395d. Payments due under Part A are financed by the Federal Hospital Insurance Trust Fund, which consists of funds appropriated by Congress in an amount equal to the hospital insurance taxes paid by employees and employers under the Federal Insurance Contributions Act

(26 U.S.C. (& Supp. III) 3101(b) and 3111(b)) and taxes paid by self-employed individuals (26 U.S.C. (& Supp. III) 1401(b)). See 42 U.S.C. (& Supp. III) 1395i(a) and (h).

Payment for services covered by Part A of the Medicare program is made directly to the hospital or other provider of the services. 42 U.S.C. (& Supp. III) 1395g.[1] The Act directs the Secretary of Health and Human Services (HHS) to determine the amount of benefits payable to the provider for services rendered to a Part A beneficiary. 42 U.S.C. (& Supp. III) 1395f, 1395g and 1395x (v). However, the Secretary is authorized to enter into a contract with a fiscal intermediary (such as a Blue Cross Association) under which the intermediary will determine the amount of benefits payable to the provider of services and make those payments to the provider on behalf of the Secretary. 42 U.S.C. (& Supp. III) 1395h. If the individual beneficiary is dissatisfied with the intermediary's initial determination of the amount of benefits payable under Part A for particular services (including a determination that no benefits are payable), the Medicare Act grants the beneficiary the right to an administrative hearing conducted by the Secretary of HHS when the amount in controversy is $100 or more and a right to judicial review when the amount in controversy is $1,000 or more. 42 U.S.C. 1395ff(b)(1)(C) and (2).[2]

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[1] The term "provider of services" is defined generally to mean a hospital, skilled nursing facility, or home health agency. 42 U.S.C. 1395x(u).

[2] The beneficiary has a right to administrative and judicial review pursuant to 42 U.S.C. 1395ff(b) of the amount of benefits payable under Part A only when he may be personally liable to the provider for the amount disallowed under Medicare—such as when reimbursement is disallowed because of certain deductible or coinsurance features, limitations on days of hospitalization, or a determination by the intermediary that hospital care was not medically necessary. 42 C.F.R. 405.704(b), as amended, 46 Fed. Reg. 24564 (May 1, 1981); see 42 U.S.C. 1395cc(a)(1)(A); *Alabama Hospital Ass'n* v. *United States*, No. 465-79C (Ct. Cl. June 17, 1981), slip op. 12. However, if an intermediary determines that the "reasonable cost" of services is less than

b. Part B of the Medicare Act establishes a voluntary program of supplementary medical insurance covering, in general, 80% of the reasonable charges for certain other medical and health services—primarily physicians' services and such items as medical supplies, x-rays and laboratory tests. See 42 U.S.C. (& Supp. III) 1395k, 1395*l*, 1395x(s), and 1395rr(b)(1). Benefits under Part B of the Medicare program are paid out of the Federal Supplementary Medical Insurance Trust Fund established in the Treasury. 42 U.S.C. 1395t(a) and (g). The Supplementary Trust Fund is supported by appropriations from the Treasury and by premiums paid by those persons who are 65 or older or disabled and who choose to enroll in the program. 42 U.S.C. (& Supp. III) 1395r(c), 1395s (f) and 1395w; see *Mathews* v. *Diaz*, 426 U.S. 67, 70 n.1 (1976).

The payment of Part B benefits is administered by private insurance carriers [3] pursuant to contracts entered into with the Secretary. 42 U.S.C. (& Supp. III) 1395u. When a claim is submitted for payment, the carrier determines whether the particular services are covered by Part B and, if they are, the amount payable for the services. The carrier also makes payments for the services on behalf of the Secretary. These payments generally are made either to the beneficiary directly or to the physician or other supplier of the Part B services to whom the beneficiary has assigned his claim. 42 U.S.C. 1395u(a)(1)

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the amount claimed by the provider, the provider cannot recover the excess amount from the beneficiary. 42 U.S.C. 1395cc(a)(1)(A); *Alabama Hospital Ass'n* v. *United States*, *supra*, slip op. 12. The provider has a right to administrative and judicial review of "reasonable cost" determinations when the aggregate amount in controversy for services rendered to all Medicare beneficiaries in a given accounting period is $10,000 or more. 42 U.S.C. 1395*oo*. The individual beneficiary has no right to administrative or judicial review of "reasonable cost" determinations, however, because he has no stake in the outcome. 42 C.F.R. 405.705(a), as amended, 45 Fed. Reg. 73932 (Nov. 7, 1980); see *Alabama Hospital Ass'n* v. *United States*, *supra*, slip op. 12.

[3] The term "carrier" is defined in 42 U.S.C. 1395u(f).

(A) and (B) and 1395u(b)(3)(B).[4] If the beneficiary is dissatisfied with the carrier's decision that Part B of the Medicare Act does not cover some or all of the services in question, or is dissatisfied with the carrier's determination of the amount payable for covered services, the Act requires that the carrier afford him the opportunity for a "fair hearing by the carrier" if the amount in controversy is $100 or more. 42 U.S.C. 1395u(b)(3)(C). If the claim has been assigned to the physician or other person who furnished the services, the assignee has the same right to a hearing by the carrier as the beneficiary. 42 C.F.R. 405.801. Unlike Part A of the Medicare Act, however, Part B contains no provision for an administrative hearing by the Secretary or judicial review of Part B claims that are denied by the carrier after the statutorily required "fair hearing" by the carrier.

2. Respondent is a major distributor of medical supplies used by patients undergoing kidney maintenance dialysis. Pet. App. 4a. For the years involved in this suit, respondent's customers included a large number of persons insured under Part B of the Medicare program.[5] Respondent accepted assignment of these persons' claims to reimbursement under Part B of the Medicare program

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[4] An exception to this rule is contained in 42 U.S.C. (& Supp. III) 1395k(a)(2) and 1395n, which provide that payments under Part B *must* be paid directly to a hospital, skilled nursing facility or similar entity on the basis of the reasonable cost of the services (rather than to the insured individual or his assignee) if the hospital or other entity furnished the services covered by Part B.

[5] By virtue of 42 U.S.C. (Supp. III) 426-1, all persons insured under the Social Security Act (and the spouses and dependent children of such insured persons) who are determined to have chronic renal disease and require hemodialysis or renal transplantation are eligible for Medicare benefits even though they have not attained age 65. This extension of coverage for persons requiring kidney maintenance dialysis or transplants first became effective for all services provided on or after July 1, 1973. See 42 U.S.C. 426(c), as added by Pub. L. No. 92-603, Section 299I, 86 Stat. 1463. Section 426(c) was revised and redesignated as Section 426-1 by Section 1 of Pub. L. No. 95-292, 92 Stat. 307.

for the supplies it furnished. See 42 U.S.C. 1395u(b)(3)(B)(ii).

The Prudential Insurance Company was designated by the Secretary as the insurance carrier for processing Part B claims in New Jersey, where respondent's business is based. Pet. App. 4a, 84a-85a. In this capacity, Prudential was responsible for determining the "reasonable charge" for supplies respondent sold to Part B beneficiaries. 42 U.S.C. 1395u(a)(1)(A) and (B). Prudential would then pay respondent 80% of the "reasonable charge" as reimbursement for the cost of those supplies. See 42 U.S.C. (& Supp. III) 1395*l*.

Under the statute, the prevailing charge made by all persons for similar services in the area during the preceding calendar year constitutes a ceiling on the "reasonable charge" that the carrier may set for services furnished by any one supplier. Specifically, for the years involved in this lawsuit, the "reasonable charge" for the particular services—80% of which would be reimbursed by the Medicare program—could not exceed the prevailing charge level that the carrier determined would cover 75% of all customary charges made for similar services in the same locality during the calendar year elapsing prior to the start of the 12-month period (beginning July 1 of each year) in which the bill was submitted or the request for payment was made. 42 U.S.C. (& Supp. III) 1395u(b)(3).[6] Because respondent's sales accounted

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[6] In December 1980, 42 U.S.C. (& Supp. III) 1395u(b)(3) was amended to provide that, effective July 1, 1981, the "reasonable charge" is to be calculated by reference to the prevailing charge in the locality during the calendar year preceding the 12-month period (beginning each July 1) in which the services were rendered, not the 12-month period in which the bill for the services was submitted to the carrier or the request for payment by the carrier was made. See Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, Section 946, 94 Stat. 2642-2643. The 1980 amendment has no bearing on the issues involved in this case. The pertinent portion of 42 U.S.C. 1395u(b)(3) previously had been amended in 1976 (Pub. L. No. 94-368, Section 3(b), 90 Stat. 997) to account for a

for almost all of the sales of the relevant supplies in New Jersey, where respondent's business was based, respondent's sales price for a particular product during the preceding calendar year established the prevailing charge level for that product and thereby became the "reasonable charge" on which respondent's 80% reimbursement was based. Pet. App. 4a-5a, 55a, 84a-85a.[7]

When respondent sold its dialysis supplies to persons who were insured under Part B of the Medicare program, it received assignments of their claims to reimbursement from Medicare. Respondent then submitted invoices to Prudential based on the prices in effect at the time it sold products to the beneficiaries from whom it had received assignments. Supp. Pet. ¶¶ 27, 43, 63.[8] However, because 42 U.S.C. (& Supp. III) 1395u(b)(3) requires that reimbursements be limited by the prevailing charge level in the *preceding* calendar year and because respondent's own sales established that level, Prudential reimbursed respondent on the basis of the prices contained in the catalogue issued by respondent on July 1 of the preceding calendar year. Thus, for invoices submitted between July 1, 1975 and June 30, 1976, Prudential reimbursed respondent on the basis of prices contained in respondent's July 1, 1974 catalogue.

Early in 1976, respondent requested that Prudential adjust the amounts of past and future reimbursements to reflect price increases that became effective after July 1, 1974. Pet. App. 6a, 35a-36a, 58a-59a, 78a; Supp. Pet.

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change in the federal government's fiscal year (see Pet. App. 4a n.4), but that amendment made no substantive change and likewise does not affect the issues involved in this case.

[7] Respondent issued an annual catalogue, effective July 1 of each year, that listed its prices for its products, whether or not they were sold to persons insured under Medicare. Respondent also issued catalogue supplements on occasion during the ensuing 12 months to reflect price changes. Pet. App. 5a.

[8] "Supp. Pet." refers to respondent's supplemental petition—*i.e.*, its complaint—in the Court of Claims.

¶¶ 30, 46 and 66.[9] Pursuant to Section 5010.2 of HHS's Part B Carriers Manual (Pet. App. 69a), which allows for adjustments in the amount of customary charges in "highly unusual situations where equity clearly indicates that the increases are warranted" (*ibid.*), Prudential granted a prospective adjustment in respondent's reimbursable "reasonable charge" for sales of the drug heparin made on or after May 26, 1976. Pet. App. 5a-6a; Supp. Pet. ¶ 47.[10] Prudential declined, however, to make a retroactive adjustment for heparin (Pet. App. 5a-6a).[11] For the other products involved in this case, moreover, Prudential declined to make either a retroactive *or* a prospective adjustment in the "reasonable charge" that was calculated on the basis of the July 1, 1974 catalogue price.[12] Prudential's initial determinations to limit adjustments in the manner described above were affirmed following a "fair hearing" by Prudential's hearing officer

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[9] In its complaint in the instant case, respondent alleged (Supp. Pet. ¶¶ 28, 44, 64) that it received periodic lump sum reimbursement payments from Prudential that totaled less than the amount claimed in the corresponding invoices, but that Prudential did not identify the reason for the disallowance. Respondent alleged that it subsequently discovered—apparently early in 1976 (Supp. Pet. ¶¶ 29, 45; see also *id.* at ¶ 65)—that Prudential was reimbursing it on the basis of the July 1, 1974 catalogue prices.

[10] This prospective adjustment was apparently occasioned by the shortage of meat from which heparin is manufactured and a resulting increase in the price of heparin by the manufacturers from which respondent purchased the drug for subsequent resale to dialysis patients. Pet. App. 5a-6a; Supp. Pet. ¶ 40.

[11] Prudential made a prospective adjustment, effective February 10, 1976, in the "reasonable charge" for another item for which the price allegedly had been misprinted in respondent's July 1, 1974 catalogue. Pet. App. 35a-36a; Supp. Pet. ¶¶ 24, 25 and 31. This aspect of the case, which was the subject of Count I of the Supplemental Petition in the Court of Claims, was subsequently settled by the parties and is not involved here. Pet. App. 1a n.1.

[12] Of course, for invoices submitted after July 1, 1976, reimbursement would have been made on the basis of respondent's July 1, 1975 catalogue, thereby resulting in increased reimbursement.

pursuant to 42 U.S.C. 1395u(b)(3)(C). See Pet. App. 6a, 34a-88a.

3.*a.* Following the decisions by Prudential's hearing officer, respondent filed the instant action in the Court of Claims, contending that Prudential's actions in denying increased reimbursements were inconsistent with the Medicare Act and violated the due process and equal protection guarantees of the Fifth Amendment.[13]

On cross-motions for summary judgment, the Court of Claims rejected the government's argument that the court lacked jurisdiction to decide respondent's reimbursement claims. The Court of Claims concluded (Pet. App. 6a-7a) that, on its face, respondent's contention—that Prudential's decision not to base reimbursement on respondent's current prices violated the Fifth Amendment and the Medicare Act—"states a claim" within the court's jurisdiction under the Tucker Act, 28 U.S.C. 1491. The court then rejected the government's contention that the text and legislative history of the Medicare Act nevertheless demonstrate Congress' intent not to subject a carrier's reimbursement determinations under Part B to judicial review.

The court acknowledged (Pet. App. 9a) that, in 42 U.S.C. 1395ff, Congress has expressly provided an individual beneficiary under Part A of the Medicare pro-

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[13] Respondent also contended (Supp. Pet. ¶¶ 37(c), 53(c), and 71(c)) that Prudential's failure to make the requested readjustments of reimbursements constituted a taking of respondent's property without just compensation, in violation of the Fifth Amendment. In making that assertion, respondent presumably intended to seek just compensation in the Court of Claims for the alleged taking, although the Request for Relief in the Supplemental Petition (at 35-37) does not refer to just compensation. The Court of Claims did not address respondent's taking claim, apparently finding it wholly without merit, and there is no occasion for this Court to consider that claim.

gram with a right to judicial review of the amount of benefits payable for particular Part A services, but has provided no such right for Part B beneficiaries or their assignees. Nevertheless, the court did not consider this omission to be sufficient evidence of Congress' intent to foreclose judicial review under Part B. In the court's view, 42 U.S.C. 1395ff establishes only the procedures to be utilized in obtaining judicial review of the particular determinations referred to in that section, and does not limit the availability of review to the determinations specifically mentioned therein. Thus, the court reasoned (Pet. App. 10a-11a), quoting *Whitecliff, Inc.* v. *United States*, 536 F.2d 347, 351 (Ct. Cl. 1976), cert. denied, 430 U.S. 969 (1977)):

> Where the Medicare statute provides for review, providers and courts must follow the specified procedures and limitations; in other cases, a provider may obtain judicial review, under the general jurisdictional provisions which are applicable, at least so far as to ensure compliance with statutory and constitutional provisions.

The court concluded (Pet. App. 11a) that 28 U.S.C. 1491 is such a "general jurisdictional provision[]" for judicial review, and that judicial review of Medicare Part B determinations is therefore available in the Court of Claims notwithstanding Congress' failure to authorize judicial review of such determinations in the Medicare Act itself.[14]

The court likewise declined to attach significance to a passage in the Senate Report on the original Medicare Act stating that the Act "does not provide for judicial

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[14] The court also observed (Pet. App. 10a & n.6) that it had "refused" in *Whitecliff, Inc.* v. *United States*, *supra*, to "extend" the holding in *Weinberger* v. *Salfi*, 422 U.S. 749 (1975)—that 42 U.S.C. 405(h) bars judicial review of benefit determinations except where expressly authorized in the Social Security Act itself—to the Medicare Act, even though 42 U.S.C. 405(h) is expressly made applicable to the Medicare Act. See 42 U.S.C. 1395ii.

review of a determination concerning the amount of benefits under Part B where claims will probably be for substantially smaller amounts than under Part A" (S. Rep. No. 404, 89th Cong., 1st Sess. 55 (1965)) and a similar statement made during floor consideration of the 1972 amendments to 42 U.S.C. 1395ff that "[t]he situations in which medicare decisions are appealable to the courts were intended in the original law to be greatly restricted in order to avoid overloading the courts with quite minor matters" (118 Cong. Rec. 33992 (1972)). The court acknowledged that these statements reflected an intent to bar claims challenging the amount of reimbursement allowed in particular instances—"as, for example, a carrier's determination that $50 rather than the $100 a physician charged was a reasonable amount for the services" (Pet. App. 14a). But this purpose to bar a flood of small claims would not be thwarted, the court reasoned, "by permitting judicial review of contentions that particular benefit determinations violated constitutional or statutory provisions. For once a particular contention of that kind had been adjudicated, that issue would be settled, and there would be no occasion for further litigation of the point" (*id.* at 14a-15a). Accordingly, the court did not find the statements in the legislative history to constitute what it believed to be the requisite "clear and convincing" evidence of a congressional intent to preclude judicial review of Part B determinations (*id.* at 12a-13a, 14a).

b. On the merits, the Court of Claims rejected respondent's contention that the "reasonable charge" on which reimbursement is based under the Act must be the amount respondent actually billed for particular services, irrespective of the prevailing charge level during the preceding calendar year. The court found (Pet. App. 18a) that Congress clearly had provided otherwise in 42 U.S.C. 1395u(b)(3). The court also concluded (*id.* at 21a) that governing regulations permit carriers to make adjustments in reimbursements in special cir-

cumstances,[15] but that the determination whether to grant an adjustment is within the discretion of the carrier and the court could not "direct Prudential whether or how to exercise that discretion in a particular case" (*ibid.*).

Despite this expression of deference to a carrier's decision whether to grant an adjustment, the court concluded that Prudential had erred when it denied a retroactive adjustment of reimbursements for the drug heparin. The court determined (*id.* at 19a-20a) that Prudential's hearing officer should not have relied on an HHS directive providing that adjustments could be prospective only, because, in the court's view, that particular directive had become obsolete. The court also concluded that Prudential's hearing officer should not have relied on two letters from HHS officials that stated the same rule (see Pet. App. 46a-48a), finding that they "cannot be deemed to reflect the considered judgment of the Secretary" (Pet. App. 20a). The court therefore remanded this aspect of the case to Prudential to determine whether a retroactive adjustment should or could be made for sales of heparin on the basis of whatever standards and policies the Secretary has promulgated for retroactive adjustments. *Id.* at 20a-21a.

The Court of Claims also found that Prudential had erred in the manner in which it calculated the prevailing charge level for respondent's supplies in the preceding calendar year. The court concluded that Prudential had violated the requirement in 42 U.S.C. 1395u(b)(3) that the prevailing charge level be calculated on the basis of charges made in the locality for similar services "*during* the last preceding calendar year" (Pet. App. 15a-16a) (emphasis added), because Prudential looked only to the respondent's catalogue charges in effect on July 1, the *midpoint* of the preceding calendar year. In the court's view, Prudential was required to take into account prices charged throughout the year, including those in effect before July 1, which may have been lower

[15] But see 42 U.S.C. (& Supp. III) 1395u(b)(3) and 42 C.F.R. 405.504 (reasonable charge limited by prevailing charge level).

than the catalogue price, as well as any price increases that became effective later in the calendar year. The court therefore remanded the case to Prudential to redetermine the "reasonable charge" for all of respondent's supplies in accordance with its opinion (Pet. App. 18a).[16]

Finally, the court found "insubstantial" respondent's contention that Prudential's failure to reimburse it on the basis of its prices in effect when the services were rendered, rather than prevailing charge levels in the preceding calendar year, resulted in a denial of due process and equal protection (Pet. App. 22a). The court found it reasonable for Congress, "in order to control Medicare costs and to provide an orderly system for administering this vast and complex program, to base reimbursement upon charges made during the prior year" (Pet. App. 22a).

SUMMARY OF ARGUMENT

I.

The Court of Claims' assumption of jurisdiction under 28 U.S.C. 1491 to review determinations by insurance carriers of amounts payable in reimbursement for par-

[16] Respondent had not challenged the manner in which Prudential calculated the prevailing charge level on this ground. This failure perhaps can be explained by the existence of Section 5010.1 of the Carriers Manual (Pet. App. 89a-90a). That section expressly allows a carrier to utilize a price list in effect at the midpoint of the calendar year (albeit June 30, not the July 1 date used by Prudential here) in calculating a supplier's customary charges for the entire year if the carrier does not have adequate statistics on prices charged by the supplier at different times throughout the year. In any event, it is entirely possible that the use of a price list in effect at the *midpoint* of the year would yield approximately the same level of reimbursement as would a weighted average of the prices charged throughout the year. If so, the remand ordered by the Court of Claims would have little or no effect on the total amount of reimbursement respondent would receive. This Court need not consider the proper method of calculating prevailing charge levels, however, because only the issue of the Court of Claims' jurisdiction is presented for review here.

ticular services under Part B of the Medicare Act conflicts with Congress' intent, clearly expressed in the text and legislative history of the Medicare Act, to bar judicial review of these very determinations.

A. Congress chose to entrust the administration of the Part B Medicare program, which now entails review of more than 150 million claims annually, to private insurance carriers that are experienced in the determination and payment of such claims under private insurance policies. Accordingly, the carrier responsible for administering the Part B program in a particular area determines whether the services for which reimbursement is sought are covered by Part B and, if so, how much should be paid in reimbursement for those services.

The only provision in the Act for review of the carrier's initial reimbursement determination under Part B is contained in 42 U.S.C. 1395u(b)(3)(C), which requires the *carrier* to conduct a "fair hearing" on the claim if the amount in controversy is $100 or more. That section does not provide for an administrative hearing by the Secretary or judicial review of the carrier's decision after a hearing.

Nor is judicial review of Part B claims authorized by 42 U.S.C. 1395ff(b), which contains the sole provisions for administrative and judicial review at the request of a Medicare beneficiary. Section 1395ff(b) grants a right to an administrative hearing by the Secretary and subsequent judicial review in federal district court of an individual's eligibility to participate under the Part A and Part B programs, but that section furnishes a right to administrative and judicial review of the amount of benefits payable for particular services only under Part A. In these circumstances, accepted principles of statutory construction compel the conclusion that Congress' withholding of a right to judicial review of benefit amount determinations under Part B was deliberate and that such review is thereby foreclosed.

Moreover, 42 U.S.C. 1395ff(b)(2) grants a right to judicial review of benefit amount determinations under

Part A only if there is at least $1,000 in controversy. It would be anomalous for Congress so to limit judicial review of reimbursement determinations under the hospital insurance program in Part A, and yet to permit suits for the lesser amount involved in the typical Part B claim without regard to the amount in controversy, as respondent apparently argues. In addition, Congress has authorized judicial review of amount determinations under Part A only after the Secretary has conducted an administrative hearing on the claim. It is most unlikely that Congress would have granted a right to sue the *United States* to obtain judicial review of a *carrier's* reimbursement decision under Part B, which does not provide a similar opportunity for prior administrative review by the Secretary to determine whether the carrier erred.

The legislative history of the Medicare Act and the 1972 amendments thereto confirms that Congress intended to foreclose judicial review of Part B claims. The Senate Report on the original Act emphasizes that "carriers, not the Secretary, would review beneficiary complaints regarding the amount of benefits" under Part B and that the Act does not provide for judicial review of the amount of benefits under Part B because they would involve smaller amounts than claims under Part A. S. Rep. No. 404, 89th Cong., 1st Sess. 54-55 (1965). And the report makes clear that the provisions in the Medicare Act for review of determinations under Parts A and B—which, with respect to amount determinations under Part B, were limited to a hearing by the carrier—were intended to be "exclusive" (*ibid.*). Congress reiterated this intent when it amended 42 U.S.C. 1395ff(b) in 1972 to clarify the limitations on review embodied in the Act as originally passed. The Conference Report on the 1972 amendments states, for example, that "there is no authorization for an appeal to the Secretary or for judicial review on matters solely involving amounts of benefits under Part B." H.R. Conf. Rep. No. 92-1605, 92d Cong., 2d Sess. 61 (1972).

The courts of appeals have acknowledged this clear congressional intent and uniformly have concluded that

judicial review of Part B reimbursement claims is barred in district court. The Court of Claims' decision in this case is inconsistent with these holdings and threatens to expose the Court of Claims to the very flood of small claims Congress sought to avoid.

B. The Court of Claims also is barred by Section 205(h) of the Social Security Act, 42 U.S.C. 405(h), from reviewing a carrier's reimbursement determination under Part B of the Medicare Act. Section 205(h) is incorporated into the Medicare Act through 42 U.S.C. 1395ii. The second sentence of 42 U.S.C. 405(h) provides that "[n]o findings of fact or decision of the Secretary shall be reviewed by any person, *tribunal*, or governmental agency except as herein provided" (emphasis added). Because a carrier acts as the agent of the Secretary in considering Part B claims, no "tribunal"—in this case, the Court of Claims—may review the carrier's findings of fact or decision except as provided in the Medicare Act itself. Since nothing in the Medicare Act so provides, judicial review of Part B claims is foreclosed by 42 U.S.C. 405(h).

The Court of Claims has read 42 U.S.C. 405(h) to bar jurisdiction under 28 U.S.C. 1491 of claims arising under Title II of the Social Security Act, but it has refused to apply 42 U.S.C. 405(h) to bar claims under the Medicare Act. See *Whitecliff, Inc.* v. *United States*, 536 F.2d 347, 350-351 (Ct. Cl. 1976), cert. denied, 430 U.S. 969 (1977), upon which the Court of Claims relied in the instant case. These holdings are inconsistent with 42 U.S.C. 1395ii, which provides that 42 U.S.C. 405(h) shall apply in Medicare cases "to the same extent" as in cases under Title II of the Social Security Act. Moreover, contrary to the apparent view of the Court of Claims in *Whitecliff* and the instant case, this Court did not suggest in *Johnson* v. *Robison*, 415 U.S. 361 (1974), that it might be unconstitutional for Congress to bar judicial review of administrative benefit determinations. The Court indicated that a constitutional question would arise only if judicial review of *constitutional* claims were barred, an issue not involved in this case.

II.

The holding of the Court of Claims that it had jurisdiction over this case under the Tucker Act, 28 U.S.C. 1491, is in direct conflict with established principles defining that court's jurisdiction under the Tucker Act. This Court has made clear that the Tucker Act merely confers jurisdiction on the Court of Claims whenever there is a substantive right, derived from some other source, to recover money damages in a suit against the United States. See *United States* v. *Mitchell*, 445 U.S. 535, 538 (1980); *United States* v. *Testan*, 424 U.S. 392, 398 (1976). The conferral of a right enforceable against the United States for money damages—and the consequent triggering of the Court of Claims' Tucker Act jurisdiction—"cannot be implied but must be unequivocally expressed." *United States* v. *King*, 395 U.S. 1, 4 (1969). The Medicare Act contains no such "unequivocally expressed" consent to suit against the United States on reimbursement claims under Part B. To the contrary, the text and legislative history of the Medicare Act manifest a clear congressional intent to bar such suits.

Contrary to respondent's contention, the mere fact that the Medicare Act provides for *private insurance carriers* to pay money in reimbursement for services they find to be covered by the Act and implementing regulations does not imply that Congress intended to render the *United States* potentially liable for damages, and for the expense and burden of litigation under the Tucker Act, every time a carrier allegedly errs in calculating the reimbursement due on one of the millions of Part B claims filed each year. Moreover, the third sentence of 42 U.S.C. 405(h), as incorporated in 42 U.S.C. 1395ii, expressly bars the district courts from exercising their Tucker Act jurisdiction (28 U.S.C. 1346(a)(2)) to entertain an action to recover on a claim under the Medicare Act. It is most unlikely that when Congress enacted the Medicare Act and expressly declined to waive the government's sovereign immunity to suit for money damages in the district court

under the Tucker Act, it nevertheless implicitly conferred a substantive right to recover money damages in a suit under the Tucker Act in the Court of Claims.

ARGUMENT

I. THE MEDICARE ACT BARS JUDICIAL REVIEW OF AN INSURANCE CARRIER'S DETERMINATION OF THE AMOUNT PAYABLE FOR PARTICULAR SERVICES UNDER PART B OF THE ACT

The Court of Claims' assumption of jurisdiction under 28 U.S.C. 1491 to review determinations by insurance carriers of amounts payable for particular services under Part B of the Medicare Act conflicts with Congress' clearly expressed intent to preclude judicial review of those very determinations. This congressional intent is evident in both the text and legislative history of the Medicare Act itself and in Section 205(h) of the Social Security Act, 42 U.S.C. 405(h), which is incorporated into the Medicare Act. See 42 U.S.C. 1395ii.

A. The Text And Legislative History Of The Medicare Act Establish That Congress Intended To Foreclose Judicial Review Of Determinations Of Amounts Payable Under Part B

The text of the Medicare Act makes clear that Congress carefully considered the types of determinations under the Act that should be subject to administrative and judicial review and that Congress deliberately foreclosed such review of Part B benefit determinations.

As the Court of Claims recognized in this case (Pet. App. 19a), respondent's right to obtain reimbursement from Prudential for its sales of supplies to persons enrolled under Part B of the Medicare Act derives solely from those persons' assignment to respondent of their individual claims to reimbursement under the Act. See 42 U.S.C. 1395u(b)(3)(B)(ii). Accordingly, respondent

has only those rights of review of reimbursement claims that are available to the individual Part B enrollees from whom it has accepted assignments. See 42 C.F.R. 405.801(a); *Kechijian* v. *Califano*, 621 F.2d 1, 4 n. 4 (1st Cir. 1980); *Szekely* v. *Florida Medical Ass'n*, 517 F.2d 345 (5th Cir. 1975), cert. denied, 425 U.S. 960 (1976); cf. 42 U.S.C. 1395pp(d).[17]

The Part B Medicare program is vast and complex. We have been informed by HHS, for example, that more than 158 million individual reimbursement claims were submitted to carriers by or on behalf of persons enrolled under the program in 1980. See also *McClure* v. *Harris*, 503 F. Supp. 409, 416 (N.D. Cal. 1980) (124 million Part B claims filed in 1978). The Act assigns the responsibility for determining whether particular services are covered by Part B and the amount of reimbursement due for covered services in individual cases not to the Secretary, but to private insurance carriers with which the Secretary has entered into contracts for the administration of the Part B program in particular geographical areas. 42 U.S.C. (& Supp. III) 1395u. Congress

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[17] When Congress has thought it appropriate to grant an independent right of review to the person or entity that furnished services under the Medicare Act, it has expressly so provided. Thus, under 42 U.S.C. 1395*oo*, which was added in 1972 (Pub. L. No. 92-603, Section 243(a), 86 Stat. 1421), Congress has granted hospitals and other providers of services under Part A a separate right to administrative and judicial review of reimbursement determinations when the amount in controversy is $10,000 or more. See also 42 U.S.C. 1395ff(c) and 1395pp(d). Similarly, in 42 U.S.C. (Supp. III) 1395rr(b)(2)(D), Congress has granted facilities furnishing end stage renal disease services under Parts A and B a right of review pursuant to 42 U.S.C. 1395*oo*. Respondent does not qualify under this provision because it is not a facility for these purposes. 42 U.S.C. (Supp. III) 1395rr(b)(9). Congress has not granted an independent right of judicial review to a supplier of services under Part B. Accordingly, respondent's procedural rights must derive from those of persons enrolled under Part B who have assigned their claims to respondent.

chose to rely on insurance carriers to administer the Part B program because they are experienced in determining reasonable and customary charges for physicians' and other medical services in their respective localities by virtue of their insurance business in the private sector and therefore can process comparable Medicare reimbursement claims more efficiently than could a government agency. S. Rep. No. 404, 89th Cong., 1st Sess. 53-54 (1965); H.R. Rep. No. 213, 89th Cong., 1st Sess. 46 (1965); 42 C.F.R. 421.5(b).

1. ***The Text of the Medicare Act Shows that Congress Foreclosed Judicial Review of Part B Amount Determinations***

a. The Medicare Act prescribes a specific avenue for review of Part B reimbursement claims that initially have been denied by the carrier, in whole or in part. If the amount in controversy after the initial determination by the carrier is $100 or more, the Act requires that the individual Part B beneficiary be given "an opportunity for a fair hearing *by the carrier.*" 42 U.S.C. 1395u (b)(3)(C) (emphasis supplied).[18] If, as in the present case, the person enrolled under Part B has assigned his reimbursement claim to a physician or other person who furnished the services, the Secretary has provided by regulation that the carrier must furnish the same hear-

[18] As originally enacted in 1965, the Act required the carrier to provide an opportunity for a "fair hearing" without regard to the amount in controversy. See Social Security Amendments of 1965, Pub. L. No. 89-97, Section 102, 79 Stat. 310-311. In 1972, 42 U.S.C. 1395u(b)(3)(C) was amended to add the $100 amount-in-controversy requirement. See Social Security Amendments of 1972, Pub. L. No. 92-603, Section 262, 86 Stat. 1448.

HHS regulations require an additional level of review between the initial determination and the evidentiary hearing. See 42 C.F.R. 405.807-405.812. Under these regulations, the individual Part B beneficiary or his assignee has a right to a "review determination" by the carrier, which is made on the basis of the evidence submitted to the carrier at the time of the initial determination and any additional information the claimant chooses to submit. There is no amount-in-controversy requirement for this "review determination."

ing rights to the assignee. 42 C.F.R. 405.801(a).[19] However, 42 U.S.C. 1395u(b)(3)(C) contains no provision for an administrative hearing by the Secretary or judicial review of a claim that is denied after the "fair hearing by the carrier."[20] Thus, there is nothing in 42 U.S.C. 1395u(b)(3)(C)—the only section of the Medicare Act specifically dealing with review of reimbursement claims under Part B—to support a right to judicial review of those claims. Nor is there any support elsewhere in the Act for such a right to judicial review. Indeed, the structure of the Act affirmatively shows that Congress deliberately withheld judicial review of reimbursement claims under Part B.

b. The sole provisions for judicial review of Medicare determinations at the request of the Medicare beneficiary are contained in 42 U.S.C. 1395ff(b). See pages 3-4, *supra.* That subsection furnishes a right to an administrative hearing by the Secretary and subsequent judicial review

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[19] The Medicare Act itself does not require the carrier to provide an opportunity for an evidentiary hearing to a physician or other supplier of Part B services to whom the individual beneficiary has assigned his reimbursement claim. It requires only that the carrier provide a hearing to the "*individual* enrolled under [Part B]." 42 U.S.C. 1395u(b)(3)(C) (emphasis added). Thus, by virtue of the Secretary's regulation extending hearing rights to assignees of Part B claims as well, respondent has been accorded the opportunity for more extensive review of its reimbursement claims than was granted by Congress.

[20] In *McClure* v. *Harris*, 503 F. Supp. 409 (N.D. Cal. 1980), the district court held that the Part B hearing procedures violate the claimant's due process rights because they do not provide for an evidentiary hearing by the Secretary after a carrier has denied a Part B claim. The government has taken a direct appeal from the final judgment in *McClure*, which was entered on May 5, 1981. The jurisdictional statement in *McClure* was filed on July 31, 1981. On June 12, 1981, Justice Rehnquist granted a stay of the district court's judgment pending appeal (No. A-961, Oct. Term 1980).

to any person who is dissatisfied with the Secretary's determination as to (1) whether he meets the conditions prescribed in 42 U.S.C. (& Supp. III) 426 and 426a for entitlement to participate in the hospital insurance program under Part A; (2) whether he is eligible to enroll and has enrolled in the supplementary insurance program under Part B; or (3) the amount of benefits payable under Part A (including a determination that no benefits are payable under Part A in a particular case).[21] Because in 42 U.S.C. 1395ff(b) Congress expressly provided a right to judicial review under Part A with respect to both an individual's eligibility to participate in the Part A program *and* the amount of benefits payable in a particular case—but provided a right to judicial review under Part B only with respect to eligibility—accepted principles of statutory construction compel the conclusion that Congress' omission of a provision for judicial review of benefit amount determinations under Part B was deliberate and that such review was thereby intended to be foreclosed. See, *e.g.*, *Lehman* v. *Nakshian*, No. 80-242 (June 26, 1981), slip op. 6; see also *Monroe* v. *Standard Oil Co.*, No. 80-298 (June 17, 1981), slip op. 14; *Fedorenko* v. *United States*, No. 79-5602 (Jan. 21, 1981), slip op. 20-21.

c. Express limitations on the availability of judicial review of benefit amount determinations under Part A further support the conclusion that judicial review of benefit amount determinations is not available under

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[21] As explained above (see note 2, *supra*), an individual beneficiary does not have a right to an administrative hearing by HHS or judicial review with respect to the amount of benefits payable under Part A when the only issue is the "reasonable cost" of the services furnished by the hospital or other provider of Part A services. The provider does, however, have a right to administrative and judicial review of reasonable cost determinations when the amount in controversy is at least $10,000. 42 U.S.C. 1395*oo*.

Part B. Section 1395ff(b)(1) provides that, when there is a right to an administrative hearing by the Secretary and judicial review of entitlement and amount determinations, those proceedings are to be conducted in accordance with 42 U.S.C. 405(b) and (g), which govern hearings and judicial review of claims under Title II of the Social Security Act, 42 U.S.C. (& Supp. III) 401 *et seq.* (Old Age, Survivors, and Disability Insurance Benefits).[22] There is no amount-in-controversy requirement that must be satisfied under 42 U.S.C. 405(b) and (g) to obtain an administrative hearing by the Secretary and judicial review of claims under Title II of the Social Security Act. But 42 U.S.C. 1395ff(b)(2) provides that, with respect to the amount of benefits payable under Part A, an administrative hearing shall not be available if the amount in controversy is less than $100 and judicial review shall not be available if the amount in controversy is less than $1,000.[23] This demonstrates that even when Congress has chosen to authorize judicial review of benefit amount determinations under the Medicare Act, it deliberately has departed from established procedures under the Social

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[22] Section 405(b) directs the Secretary to grant a right to an administrative hearing to a person who makes a showing that his rights may be prejudiced by the Secretary's initial determination. Section 405(g) grants a right to judicial review of a final decision of the Secretary made after a hearing to which the person was a party, irrespective of the amount in controversy, in a civil action commenced within 60 days in federal district court.

[23] 42 U.S.C. 1395ff(b)(2) provides:

> Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection [which provides for review of benefit amount determinations under Part A], a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

Security Act by imposing additional limitations on the availability of review in order to keep relatively minor disputes out of the courts.

Given these carefully drawn restrictions on the availability of judicial review of claims for hospital and similar benefits under Part A, it would be illogical to infer that Congress nevertheless intended to permit judicial review of carrier reimbursement determinations under Part B without regard to the amount in controversy, as respondent apparently asserts. This result would be particularly anomalous in view of the fact that the typical Part B claim—a bill for a doctor's visit, laboratory tests, x-rays, or medical supplies—would be much less in amount than the typical Part A claim for reimbursement for the costs of hospital treatment. See S. Rep. No. 404, *supra*, at 54-55.

It also is significant that, while Congress *has* authorized judicial review in 42 U.S.C. 1395ff, it has done so only in cases in which there has been a prior administrative hearing conducted by HHS, as provided in 42 U.S.C. 405(b). See 42 U.S.C. 405(g); *Weinberger* v. *Salfi*, 422 U.S. 749, 763-767 (1975); *Mathews* v. *Eldridge*, 424 U.S. 319, 328 (1976). Under Part B, however, there is no provision for administrative review by the Secretary of a carrier's determination of the amount of reimbursement due on a particular claim. It is most unlikely that Congress would have intended to permit an individual beneficiary or his assignee to *sue the United States* to recover on a claim that has been denied by the carrier, when Congress has not provided any prior opportunity for administrative review by expert agency officials in HHS to determine whether the claim should be paid without the need for litigation. See, *e.g.*, *Kuenstler* v. *Occidental Life Insurance Co.*, 292 F. Supp. 532, 536 (C.D. Cal. 1968); *Weinberger* v. *Salfi*, *supra*, 422 U.S. at 762. But cf. *McClure* v. *Harris*, *supra*, note 20.

Thus, the text and structure of the review provisions of the Medicare Act demonstrate that there is no right

to judicial review of a carrier's reimbursement determinations under Part B of the Act.[24]

2. *The Legislative History of the Medicare Act Confirms that Congress Foreclosed Judicial Review of Part B Amount Determinations*

a. The legislative history of the Medicare Act confirms that Congress intended to preclude judicial review of a carrier's determinations of the amount payable for particular services under Part B. The Senate Report on the 1965 Act unequivocally states that judicial review was not intended:

> The committee's bill provides for the Secretary to make determinations, under both the hospital insurance plan and the supplementary plan, as to whether individuals are entitled to hospital insurance benefits or supplementary medical insurance benefits and for hearings by the Secretary and judicial review where an individual is dissatisfied with the Secretary's determination. Hearings and judicial review are also provided for where an individual is dissatisfied with a determination as to the amount of benefits under the hospital insurance plan if the

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[24] A claimant cannot avoid this bar to judicial review by suing the carrier rather than the United States or an agency or officer thereof. As respondent concedes (Br. in Opp. 6), the United States would be the real party in interest in such a suit because it would pay any judgment. See also S. Rep. No. 404, *supra*, at 54; 42 C.F.R. 421.5(b); *Kuenstler* v. *Occidental Life Insurance Co.*, 292 F. Supp. 532, 535 (C.D. Cal. 1968). For this reason, the United States would defend the carrier in such litigation (28 U.S.C. 516; see *Kuenstler* v. *Occidental Life Insurance Co.*, *supra*), and thereby assume the burden of the litigation even though it was not named as a party. See also S. Rep. No. 404, *supra*, at 54 ("the Government would be expected to safeguard the interests of [the Secretary's] contractual representatives with respect to their actions in the fulfillment of commitments under the contracts and agreements entered into by them with the Secertary"). Accordingly, the preclusion of judicial review of Part B determinations by carriers necessarily applies to suits against the carriers as well.

> amount in controversy is $1,000 or more. (*Under the supplementary plan, carriers, not the Secretary, would review beneficiary complaints regarding the amount of benefits, and the bill does not provide for judicial review of a determination concerning the amount of benefits under part B where claims will probably be for substantially smaller amounts than under part A.*) Hospitals, extended care facilities, and home health agencies would be entitled to hearing and judicial review if they are dissatisfied with the Secretary's determination regarding their eligibility to participate in the program.[25] *It is intended that the remedies provided by these review procedures shall be exclusive.*

S. Rep. No. 404, *supra*, at 54-55 (emphasis added); see also H.R. Rep. No. 213, *supra*, at 47. As the last-quoted sentence makes clear, the procedure provided in 42 U.S.C. 1395u(b)(3)(C) for pursuing complaints about carrier reimbursement determinations under Part B—review by the carrier (rather than the Secretary) without subsequent judicial review—plainly was intended to be "exclusive."

b. Congress reiterated its intent to preclude judicial review of Part B claims when it revised 42 U.S.C. 1395ff (b) in 1972. The impetus for this revision was an apparent ambiguity in the wording of subsection (b) as originally enacted that had led some district courts to recognize a right to judicial review of an individual's "entitlement" to reimbursement for particular services under both Parts A and B of the Act, without regard to the amount in controversy. See, *e.g.*, *Ridgely* v. *Secretary of Dept. of Health, Education and Welfare*, 345 F. Supp. 983, 986-988 (D. Md. 1972), aff'd, 475 F.2d 1222 (4th Cir. 1973); *Bohlen* v. *Richardson*, 345 F. Supp. 124 (E.D. Pa. 1972), aff'd, 483 F.2d 918 (3d Cir. 1973);

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[25] See 42 U.S.C. 1395ff(c).

Cardno v. *Finch*, 311 F. Supp. 251 (E.D. La. 1970).[26] In response to these decisions, Congress amended 42 U.S.C. 1395ff(b) to read as it now does. This amendment makes clear that judicial review is available on questions of "entitlement" only with respect to the threshold determinations whether an individual is *eligible to participate* in the Part A program and whether he is *eligible to enroll and has enrolled* under Part B. 42 U.S.C. 1395ff(b)(1)(A) and (B). Whether a person who is participating under Part A or enrolled under Part B is "entitled" to be reimbursed for particular services is now a question of the *amount* of benefits that are payable,[27] for which judicial review is available under 42 U.S.C. 1395ff(b)(1)(C) *only under Part A*, and only if $1,000 or more is in controversy.

Senator Bennett, who introduced the amendment to 42 U.S.C. 1395ff on the Senate floor, explained the pur-

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[26] As originally enacted, 42 U.S.C. (1970 ed.) 1395ff(b) read:

> Any individual dissatisfied with any determination under subsection (a) of this section as to entitlement under part A or part B, or as to amount of benefits under part A where the matter in controversy is $100 or more, shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title, and, in the case of a determination as to entitlement or as to amount of benefits where the amount in controversy is $1,000 or more, to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

The decisions cited in the text construed the word "entitlement" in this section broadly to refer to whether particular services were covered by Part A or B (and thereby "entitled" an individual to any reimbursement in the particular case), not merely to whether the individual was eligible to participate in the Part A or Part B program at all, as Congress had intended. See also *Alabama Hospital Ass'n.* v. *United States*, No. 465-79C (Ct. Cl. June 17, 1981), slip op. 11 (Part A dispute arising before the 1972 amendment to 42 U.S.C. 1395ff(b)).

[27] This is made clear by 42 U.S.C. 1395ff(b)(1)(C), which provides for a right to administrative and judicial review of a determination as to "the amount of benefits under Part A (*including a determination where such amount is determined to be zero*)" (emphasis added).

pose of the amendment—*i.e.*, to keep minor claims, such as those under Part B, out of the courts (118 Cong. Rec. 33992 (1972); emphasis added):

> [T]he purpose of the amendment is to make sure existing law, which gives the right of a person to go to court on the question of eligibility to receive welfare, *is not interpreted to mean he can take the question of the Federal claim to court. If he did we would never have an end to it.* This is to reconfirm the original intention of the law that the courts can determine only eligibility.
>
> *The situations in which medicare decisions are appealable to the courts were intended in the original law to be greatly restricted in order to avoid overloading the courts with quite minor matters. The law refers to "entitlement" as being an issue subject to court review and the word was intended to mean eligibility to any benefits of medicare but not to decisions on a claim for payment for a given service.*
>
> If judicial review is made available where any claim is denied, as some court decisions have held, the resources of the Federal court system would be unduly taxed and little real value would be derived by the enrollees. The proposed amendment would merely clarify the original intent of the law and prevent the overloading of the courts with trivial matters because the intent is considered unclear.

The Conference Committee accepted the Senate provision proposed by Senator Bennett, explaining:

> The Senate amendment added a new section to the House bill which would make clear that *there is no authorization for an appeal to the Secretary or for judicial review on matters solely involving amounts of benefits under Part B*, and that insofar as Part A amounts are concerned, appeal is authorized only if the amount in controversy is $100 or more and judicial review only if the amount in controversy is $1,000 or more.
>
> The House recedes.

H.R. Conf. Rep. No. 92-1605, 92d Cong., 2d Sess. 61 (1972) (emphasis added).

c. In view of this unequivocal legislative history, there can be no doubt that Congress intended to foreclose judicial review of a carrier's determination of the amount of benefits due under Part B.[28] Indeed, the courts of appeals are in agreement on this point with respect to the jurisdiction of the district courts. See *Kechijian* v. *Califano*, *supra*, 621 F.2d at 3-4; *Bussey* v. *Harris*, 611 F.2d 1001, 1005 n. 5 (5th Cir. 1980); *Drennan* v. *Harris*, 606 F.2d 846, 850 n. 1 (9th Cir. 1979); cf. *St. Louis University* v. *Blue Cross Hospital Service*, 537 F.2d 283, 289 (8th Cir.), cert. denied, 429 U.S. 977 (1976); *Bohlen*, *supra*, 483 F.2d at 919 & n. 1, 922; *Ridgely*, *supra*, 475 F.2d at 1224.[29] These courts have recognized that judicial review of Part B benefit determinations would "involve the courts in the complex and detailed task of 'ascertaining the appropriate medical charges for technical services—based

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[28] The Third Circuit, on appeal of one of the cases that had prompted the 1972 amendment to 42 U.S.C. 1395ff(b), recognized that there is no right to judicial review of a carrier's benefit determinations under Part B in cases covered by the amended section. *Bohlen*, *supra*, 483 F.2d at 919 & n.1, 922; see also *Ridgely*, *supra*, 475 F.2d at 1224; *Rubin* v. *Weinberger*, 524 F.2d 497, 499 n.2 (7th Cir. 1975); *Simoncelli* v. *Weinberger*, 418 F. Supp. 87, 89-90 n.4 (E.D. Pa. 1976); *Hamilton* v. *Blue Cross of North Dakota*, 375 F. Supp. 1049 (D.N.D. 1974).

[29] See also *Monmouth Medical Center* v. *Harris*, 494 F. Supp. 590, 596 (D.N.J. 1980); *Greenspan* v. *Blue Cross Blue Shield of Greater New York*, 432 F. Supp. 1339 (E.D.N.Y. 1977). Several district courts have assumed jurisdiction under 28 U.S.C. 1331 to hear challenges to the Secretary's actions under Part B. *Schupak* v. *Califano*, 454 F. Supp. 105, 112-113 (E.D.N.Y. 1978); *Mid Atlantic Nephrology Center, Ltd.* v. *Califano*, 433 F. Supp. 23, 31-33 (D. Md. 1977). These decisions are incorrect, in our view, because jurisdiction was barred by 42 U.S.C. 405(h). See pages 33-38, *infra*. But even in these cases, the plaintiffs did not seek review of individual reimbursement decisions by a carrier, as respondent did in the instant case.

on facts which vary from community to community'" and that "'the proper amount of these charges is a matter peculiarly suited to determination by a specialized agency.'" *Kechijian* v. *Califano*, *supra*, 621 F.2d at 3, quoting *St. Louis University* v. *Blue Cross Hospital Service*, *supra*, 537 F.2d at 289. No reason appears why the preclusion of judicial review of Part B claims does not apply equally to the Court of Claims or why that court is any better suited than the district courts to review complex determinations by expert insurance carriers of the "reasonable charge" that may be paid for medical and health services covered by Part B.

If affirmed by this Court, the Court of Claims' holding that Congress' clearly expressed intent to preclude judicial review of Part B claims may be ignored would intrude that court (and perhaps the district courts as well) into the carriers' day-to-day administration of the Medicare program and open the judicial system to the very flood of small claims Congress sought to foreclose. Compare *Johnson* v. *Robison*, 415 U.S. 361, 370-373 (1974).

As noted above (see page 21, *supra*), more than 150 million reimbursement claims are now filed under Part B each year. Statistics compiled by the Department of Health and Human Services disclose that during calendar year 1980, Part B carriers such as Prudential received 2,163,786 requests for informal review of their initial determinations. See 42 C.F.R. 405.807 *et seq.*; note 18, *supra*. The carriers affirmed their initial determinations in 975,143 of these cases. During the same period, carriers received 26,171 requests for "fair hearings," and their determinations were upheld after a hearing in 7191 cases. If only a fraction of the total number of disappointed claimants were to seek review in the Court of Claims or the district courts, the cited statistics demonstrate that there would be a significant increase in the workload of these courts. This would, in turn, strain the scarce resources of the Secretary and the Attorney

General in defending against relatively minor monetary claims. Such consequences should not be imposed on the judicial and executive branches in the face of Congress' clearly expressed purpose to avoid them.

B. Section 205(h) Of The Social Security Act, As Incorporated In The Medicare Act, Also Bars Judicial Review Of Respondent's Claim

1. Section 205(h) of the Social Security Act, as codified at 42 U.S.C. (1970 ed.) 405(h), provides:

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of title 28 to recover on any claim arising under this subchapter.[30]

Section 405(h) has been incorporated into the Medicare Act "to the same extent as [it is] applicable with respect to" Title II of the Social Security Act. 42 U.S.C. 1395ii.

The insurance carrier with which the Secretary has entered into a contract for the administration of the Part B program in a particular geographical area acts on behalf of the Secretary in performing its obligations under the contract, including the holding of the "fair hearing" required by 42 U.S.C. 1395u(b)(3)(C). See S. Rep. No. 404, *supra*, at 54; 42 C.F.R. 421.5(b). Consequently, by virtue of the first sentence of 42 U.S.C. 405(h), the carrier's findings and decision after a hearing on a Part B claim are "binding upon all individuals

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[30] In the 1976 edition of the United States Code, which has not been enacted into positive law, the third sentence of Section 205(h) is changed to refer to "sections 1331 or 1346" or Title 28, rather than "section 41 of title 28" as in the Social Security Act itself.

who were parties to such hearing" in the same manner as if the hearing had been conducted by the Secretary. See also 42 C.F.R. 405.835. And because for purposes of the carrier hearing a supplier of Part B services such as respondent stands in the shoes of the individual Part B beneficiaries from whom it has accepted assignments of reimbursement claims,[31] Prudential's findings and decision with respect to the reimbursement claims tendered by respondent were binding upon respondent. See also 42 C.F.R. 405.835.

In addition, the second sentence of 42 U.S.C. 405(h) provides that "[n]o findings of fact or decision of the Secretary shall be reviewed by any person, *tribunal*, or governmental agency except as herein provided" (emphasis added). Because a carrier acts as the agent of the Secretary, no "tribunal"—in this case, the Court of Claims—may review the carrier's findings of fact or decision except as otherwise provided in the Medicare Act itself. Since nothing in the Medicare Act provides for judicial review in these circumstances, review is barred by the literal terms of the second sentence of 42 U.S.C. 405(h).[32] *Califano* v. *Sanders*, 430 U.S. 99,

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[31] See 42 C.F.R. 405.801, 405.802(b), 405.805, 405.808 and 405.822.

[32] Under this Court's decision in *Weinberger* v. *Salfi*, *supra*, the third sentence of 42 U.S.C. 405(h) likewise would bar an action in district court under 28 U.S.C. 1331 or the Tucker Act (28 U.S.C. 1346(a)(2)) on a claim arising under Part B of the Medicare Act. See *Kechijian* v. *Califano*, *supra*, 621 F.2d at 3-4; *Bussey* v. *Harris*, *supra*, 611 F.2d at 1005-1006; *Drennan* v. *Harris*, *supra*, 606 F.2d at 850; *Trinity Memorial Hospital* v. *Associated Hospital Service, Inc.*, 570 F.2d 660, 666-667 (7th Cir. 1977); *St. Louis University* v. *Blue Cross Hospital Service*, *supra*, 537 F.2d at 287-289. Because the third sentence of 42 U.S.C. 405(h), by its terms, only bars jurisdiction in the district courts, it does not literally apply to actions brought in the Court of Claims. Nevertheless, the policy clearly expressed in the third sentence of Section 405(h) that judicial review of claims under the Social Security Act (including its Medicare title) is barred except when Congress expressly has provided to the contrary applies equally to actions in the Court of

110-111 (1977) (Stewart, J., concurring in the judgment); cf. *Weinberger* v. *Salfi*, *supra*, 422 U.S. at 757. In short, Congress' incorporation of 42 U.S.C. 405(h) into the Medicare Act independently compels the conclusion that is evident from the text and legislative history of 42 U.S.C. 1395u(b)(3)(C) and 1395ff(b), discussed above—that Congress expressly has foreclosed judicial review of reimbursement decisions by insurance carriers under Part B.

2. The Court of Claims acknowledged in the instant case (Pet. App. 10a n.6) that, in *Weinberger* v. *Salfi*, *supra*, this Court construed Section 405(h) to bar review of the Secretary's determinations under Title II of the Social Security Act except as provided in Title II itself (*i.e.*, pursuant to 42 U.S.C. 405(g)). But the Court of Claims disposed of the government's contention in this case that Section 405(h) bars an action to recover on a claim under Part B of the Medicare Act

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Claims. Thus, the third sentence of Section 405(h) reinforces the plain meaning of the second sentence, which *does* expressly bar review of the Secretary's decision by *any* "tribunal", including the Court of Claims. Indeed, by the cumulation of prohibitions in 42 U.S.C. 405(h), Congress clearly has manifested its intent to foreclose all review of administrative findings and conclusions in this context. The kinds of routine findings and conclusions involved in this case—concerning the amount of reimbursement due under Part B of the Medicare Program—are at the core of Congress' manifest concern in 42 U.S.C. 405(h).

Some courts of appeals have taken the position that, notwithstanding 42 U.S.C. 405(h), the district courts have jurisdiction under 28 U.S.C. 1331 of constitutional challenges to the Medicare Act. *Chelsea Community Hospital* v. *Michigan Blue Cross Ass'n*, 630 F.2d 1131 (6th Cir. 1980); *St. Louis University* v. *Blue Cross Hospital Service*, *supra*, 537 F.2d at 291-293; see also *Kechijian* v. *Califano*, *supra*, 621 F.2d at 4. These decisions have no relevance here, because the Court of Claims found respondent's constitutional claims to be "insubstantial" (Pet. App. 22a). Moreover, respondent would not have a cause of action in the Court of Claims under 28 U.S.C. (Supp. III) 1491 to recover money damages even if it had alleged a substantial constitutional claim. See note 39, *infra*.

simply by asserting that it previously had "refused to extend *Salfi*" to Medicare cases. Pet. App. 10a n. 6, citing *Whitecliff, Inc.* v. *United States*, 536 F.2d 347, 350-351 (Ct. Cl. 1976), cert. denied, 430 U.S. 969 (1977).

In *Whitecliff*,[33] the Court of Claims did not cite anything in the language or legislative history of Section 405(h) or the Medicare Act that would justify its refusal to enforce the preclusion of judicial review in Medicare cases. Nor did the court suggest that Section 405(h) does not apply to actions in the Court of Claims. Indeed, that court has relied upon Section 405(h) in other cases to support a holding that it does not have jurisdiction of actions brought to recover disability benefits under Title II of the Social Security Act. See *Hickman* v. *United States*, No. 510-80C (Feb. 27, 1981), pet. for cert. pending, No. 80-6756; *Burton* v. *United States*, 205 Ct. Cl. 846 (1974).

Instead, *Whitecliff* reasoned that, while the effect of the reading of Section 405(h) in *Salfi* was only to channel judicial review of claims under Title II of the Social Security Act through 42 U.S.C. 405(g), the effect of giving Section 405(h) the same reading in Medicare cases would be to bar judicial review in broad categories of cases for which judicial review is not otherwise available under the Medicare Act. Such a result, the court believed, would "undermine the normal presumption in favor of judicial review" (536 F.2d at 350), and might be of doubtful constitutional validity (*ibid.*). Thus, because it concluded that judicial review should be available in some court, the Court of Claims refused to apply 42 U.S.C. 405(h) to Medicare cases.

The Court of Claims' decision in *Whitecliff*, which was followed in the instant case, is clearly incorrect. First, 42 U.S.C. 1395ii expressly provides that Section 405(h) and the other provisions incorporated into the Medicare

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[33] *Whitecliff* was an action brought in the Court of Claims by a provider of services under Part A of the Medicare Act.

Act shall apply with respect to the Medicare Act "*to the same extent* as they are applicable with respect to Title II [of the Social Security Act]" (emphasis added). Accordingly, there simply is no basis for giving Section 405(h) a less expansive reading in the instant case than has been given it in *Salfi* and other cases arising under Title II. Moreover, whatever may be the "presumption" in favor of judicial review of administrative decisions in other contexts, the language of 42 U.S.C. 405(h), 1395u(b)(3)(C), and 1395ff, and the legislative history of the Medicare Act, plainly reverse any such presumption in Medicare cases: judicial review is *not* available unless Congress expressly has so provided.

In addition, and contrary to the Court of Claims' suggestion, this Court has not indicated that it may be unconstitutional for Congress to withhold a right to judicial review of administrative determinations made pursuant to an Act of Congress (see, *e.g.*, *Califano* v. *Sanders*, *supra*), except perhaps in the case of constitutional claims. See *Johnson* v. *Robison*, 415 U.S. 361, 366-367 (1974). The statute at issue in *Johnson* v. *Robison*, 38 U.S.C. 211(a), bars judicial review of routine benefit determinations by the Veterans' Administration, yet the Court did not intimate that this broad preclusion might be unconstitutional. The Court indicated only that there would be a constitutional question raised if a judicial challenge to the *constitutionality* of the veterans' benefit statutes had been barred by 38 U.S.C. 211(a). 415 U.S. at 366-367; see *Califano* v. *Sanders*, *supra*, 430 U.S. at 109.[34] Indeed, notwithstanding its reliance on *Johnson* v. *Robison* in *Whitecliff* (536 F.2d at 350 n.7) and in the instant case (Pet. App. 11a-12a), the Court of Claims consistently has interpreted 38 U.S.C. 211(a) to bar jurisdiction in that court of actions to recover veterans' benefits, even though the result necessarily was to pre-

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[34] The Court construed 38 U.S.C. 211(a) not to bar such challenges. 415 U.S. at 366-374.

clude all judicial review. See *Baker* v. *United States*, No. 145-80C (Oct. 17, 1980); *Jennings* v. *United States*, 214 Ct. Cl. 789, 790 (1977); *Martin* v. *United States*, 197 Ct. Cl. 1062 (1972); *Jump* v. *United States*, 164 Ct. Cl. 453, 454 (1964); *Brown* v. *United States*, 150 Ct. Cl. 836, 840 (1960). The Court of Claims has offered no reason why Section 405(h) should not be given the same expansive reading here, as required by its literal terms.

Moreover, the same considerations, identified by the Court in *Johnson* v. *Robison*, which led Congress to preclude judicial review of veterans' benefit determinations —the need to avoid the expense and burden of litigation and to ensure the adequacy and uniformity of complex benefit determinations by expert administrative personnel (415 U.S. at 368-373)—apply equally to determinations by insurance carriers under Part B of the Medicare Act. Thus, it is not surprising that the courts of appeals, in contrast to the Court of Claims, uniformly have applied 42 U.S.C. 405(h) in Medicare cases "to the same extent" as it applies under Title II of the Social Security Act. 42 U.S.C. 1395ii. See the cases cited in note 32, *supra*.

II. THE DECISION BELOW IS INCONSISTENT WITH THE DECISIONS OF THIS COURT CONCERNING THE JURISDICTION OF THE COURT OF CLAIMS UNDER THE TUCKER ACT

The holding of the Court of Claims that it had jurisdiction over this case under the Tucker Act, 28 U.S.C. 1491, is in direct conflict with established principles regarding that court's jurisdiction under the Tucker Act.

A. On two recent occasions, this Court has made clear that the Tucker Act " 'does not create any substantive right enforceable against the United States for money damages,' " but rather "merely 'confers jurisdiction upon [the Court of Claims] whenever the substantive right exists.' " *United States* v. *Mitchell*, 445 U.S. 535, 538

(1980), quoting *United States* v. *Testan*, 424 U.S. 392, 398 (1976); see also *United States* v. *Hopkins*, 427 U.S. 123, 130 (1976). It is therefore necessary to look outside of the Tucker Act itself—in this case, to the Medicare Act—to find a waiver of sovereign immunity with respect to a particular claim, which would in turn trigger the jurisdictional grant in 28 U.S.C. 1491. Accordingly, the Court of Claims had jurisdiction of the instant case under 28 U.S.C. 1491 only if the Medicare Act "confer[s] a substantive right to recover money damages from the United States" (*United States* v. *Testan*, *supra*, 424 U.S. at 398) whenever a private insurance carrier may have erred in determining the amount of reimbursement to be paid on a particular claim under Part B.

The conferral of a substantive right to recover money damages in a suit against the United States—and the consequent conferral of jurisdiction on the Court of Claims under 28 U.S.C. 1491 to entertain the suit—"'cannot be implied but must be unequivocally expressed.'" *United States* v. *Mitchell*, *supra*, 445 U.S. at 538, and *United States* v. *Testan*, *supra*, 424 U.S. at 399, both quoting *United States* v. *King*, 395 U.S. 1, 4 (1969); see also *Lehman* v. *Nakshian*, *supra*, slip op. 4. The Medicare Act contains no "unequivocally expressed" consent to suit against the United States on individual reimbursement claims under Part B. To the contrary, the text and legislative history of the Medicare Act and Section 205(h) of the Social Security Act, discussed in point I, *supra*, make clear that Congress deliberately foreclosed judicial review of all Part B claims. Congress' preclusion of judicial review in 1965 and 1972 would be of no effect if a claimant could obtain such review simply by filing a suit for money damages in the Court of Claims. This Court has recognized that the Court of Claims has no jurisdiction under the Tucker Act when the statute involved manifests a congressional intent to bar judicial review of an administrative determination of benefits (*United States* v. *Babcock*, 250 U.S. 328, 331

(1919)), and the Court of Claims has adhered to this principle in other contexts. See *Shull* v. *United States*, No. 16-78 (Ct. Cl. July 10, 1981), slip op. 8-12 (considering the preclusion of review in 31 U.S.C. 242); *Hickman* v. *United States*, *supra*, and *Burton* v. *United States*, *supra* (42 U.S.C. 405(h)); *Baker* v. *United States*, and other cases cited at page 38, *supra* (38 U.S.C. 211(a)); *Fountain* v. *United States*, 427 F.2d 759 (1970), cert. denied, 404 U.S. 839 (1971) (42 U.S.C. (1964 ed. Supp. IV) 1465(e)). There is no basis for the Court of Claims' failure to apply that principle in the instant case.

B. Respondent argues, however, that 28 U.S.C. 1491 constitutes a general grant of jurisdiction over suits for money damages for a statutory violation wherever a federal statute " 'can fairly be interpreted as mandating compensation by the Federal Government for the damage sustained' " (Br. in Opp. 6, quoting *United States* v. *Testan*, *supra*, 424 U.S. at 400, and *Eastport Steamship Corp.* v. *United States*, 372 F.2d 1002, 1009 (Ct. Cl. 1967)). Respondent contends that the Medicare Act should be so interpreted because, in its view, "Medicare legislation, fairly read, mandates appropriate payment to providers" (Br. in Opp. 6). Having thus hypothesized a *general* grant of jurisdiction under 28 U.S.C. 1491 over all cases arising under statutes that provide for the payment of monetary benefits, respondent concludes (Br. in Opp. 7-12) that Congress did not intend to "carve[] out an exception" (*id.* at 7) to this general grant of jurisdiction applicable to Part B claims. The Court of Claims followed a similar approach, viewing the question presented as whether the Medicare Act "repealed by implication a portion of [its] jurisdiction under the Tucker Act" (Pet. App. 9a). This analysis is seriously flawed.

Contrary to the views of respondent and the Court of Claims, the question presented by this case is not whether the Medicare Act has withdrawn or "repealed" jurisdiction that could be said to have been conferred on the

Court of Claims by the Tucker Act itself. The Tucker Act is only a *conditional* grant of jurisdiction: it confers jurisdiction on the Court of Claims only when some *other* statute affirmatively confers a substantive right to recover money damages in a suit against the United States. Accordingly, the question presented is whether the Medicare Act affirmatively creates a right to sue the United States and thereby triggers the *grant* of jurisdiction to the Court of Claims, not whether the Medicare Act *withdraws* or *repeals* a grant of jurisdiction that has been independently conferred.[35] As we have explained above, the Medicare Act plainly does not confer a substantive right to recover money damages in a suit against the United States.

Surely, the mere fact that Part B of the Medicare Act provides for *private insurance carriers* to pay money in

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[35] Thus, respondent and the Court of Claims err in their reliance on the statement that the Tucker Act confers jurisdiction over cases arising under a federal statute whenever that statute "'can fairly be interpreted as mandating compensation by the Federal Government for the damage sustained'" as a result of a violation (*United States* v. *Testan*, *supra*, 424 U.S. at 400, quoting *Eastport Steamship Corp.* v. *United States*, *supra*, 372 F.2d at 1009). The quoted language is not a rule for construing the Tucker Act. Rather, it is a tool of statutory construction that can be utilized in determining whether some *other* federal statute (here, the Medicare Act) confers a substantive right to sue the United States to recover money damages and thereby triggers the conditional grant of jurisdiction in the Tucker Act. Whether the Medicare Act affirmatively confers such a right requires an analysis of the Medicare Act as a whole, including the nature of the benefits conferred, the number and complexity of reimbursement determinations, the provisions for administration of the Part B program by insurance carriers without Secretarial review, and the provisions precluding judicial review of carrier determinations. The fact that the Medicare Act provides for the payment of monetary benefits is only one element of the broader inquiry whether the United States has waived its immunity to *suit* for money damages. That Congress has chosen to distribute monetary benefits administratively—or, here, through private insurance carriers—does not mean that Congress intended to expose the United States to *suit* on a claim for such benefits. Compare *Johnson* v. *Robison*, *supra*.

reimbursement for services they find to be covered by the Act and implementing regulations does not, contrary to respondent's contention (Br. in Opp. 6), mean that Part B can "fairly be interpreted as mandating compensation by the *Federal Government* for the damage sustained" (*United States* v. *Testan*, *supra*, 424 U.S. at 400; emphasis added) every time a carrier errs in calculating the reimbursement due on one of the millions of Part B claims filed each year.[36] When Congress barred administrative appeals to the Secretary and APA-type judicial review of adverse reimbursement determinations by the carriers, it concluded that the relatively small amount of money involved in the typical Part B claim did not warrant the expense and burden of a review mechanism beyond the provision in 42 U.S.C. 1395u(b)(3)(C) for a fair hearing by the carrier. It would be entirely inconsistent with this statutory scheme and with Congress' decision to entrust the administration of the Part B program to expert insurance carriers in the private sector for Congress nonetheless to have rendered the United States potentially liable in money damages, and for the expense and burden of litigation under the Tucker Act, for every allegedly erroneous determination made by a carrier.

C. Moreover, in the third sentence of 42 U.S.C. 405(h), which is incorporated into the Medicare Act through 42 U.S.C. 1395ii, Congress has expressly foreclosed the *district courts* from exercising their Tucker Act jurisdiction (28 U.S.C. 1346(a)(2)) to entertain actions against the United States to recover on any claim arising under the Medicare Act.[37] It is most unlikely that when

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[36] As explained above (see page 26, *supra*), it is most unlikely that Congress would have created a substantive right to recover money damages in a suit against the United States without providing for prior administrative review by the Secretary of the particular Part B claim.

[37] The third sentence of Section 405(h) provides that "[n]o action against the United States * * * shall be brought under sec-

Congress enacted the Medicare Act and expressly declined to waive the government's sovereign immunity to suit for money damages in district court under the Tucker Act, it nevertheless implicitly created a substantive right to recover money damages in a suit under the Tucker Act in the Court of Claims.[38]

Finally, the manner in which the Court of Claims will exercise its jurisdiction in these cases demonstrates the error of its jurisdictional holding. The Court of Claims stated (Pet. App. 14a) that it would not actually review the amount of reimbursement found to be due in a particular case. Rather, if the court finds a statutory error, as it did in this case, it will remand to the carrier to redetermine the reimbursement under what the court finds to be the appropriate standards. Thus, the court will not award a judgment of "actual, presently due money damages" (*United States* v. *King*, *supra*, 395 U.S. at 3), but will, instead, grant a form of equitable or declaratory relief by way of remand. This underscores

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tion 41 of title 28 to recover on any claim arising under this subchapter." Prior to the 1948 revision of title 28 of the United States Code, Section 41 of that title contained all of the title's general grants of jurisdiction to United States district courts. *Weinberger* v. *Salfi*, *supra*, 422 U.S. at 756 n.3. Paragraph 20 of Section 41 contained the grant of jurisdiction under the Tucker Act to the District Courts, concurrent with that of the Court of Claims, where the amount in controversy does not exceed $10,000. See 28 U.S.C. (1940 ed.) 41(20). The version of 42 U.S.C. 405(h) in the 1976 edition of the United States Code expressly refers to 28 U.S.C. 1346, which now contains the grant of Tucker Act jurisdiction to the district courts.

[38] When Congress has provided for judicial review under the Medicare Act, it has mandated that the procedures in 42 U.S.C. 405(g) be followed (see 42 U.S.C. 1395ff(b)), including the requirement that a petition for review be filed within 60 days of the Secretary's decision. In contrast, a claimant presumably would have six years to bring an action in the Court of Claims under the Tucker Act. See 28 U.S.C. 2401. Congress could not have intended such a result. See *Califano* v. *Sanders*, *supra*, 430 U.S. at 108.

the conclusion that reimbursement determinations under Part B of the Medicare Act cannot properly be reviewed in a suit for money damages in the Court of Claims under the Tucker Act. *United States* v. *Testan, supra*, 424 U.S. at 404-405; *United States* v. *King, supra*; see Rogers, *A Way Out of the Social Security Jurisdiction Tangle*, 21 Ariz. L. Rev. 689, 719-721 (1979).[39]

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[39] In addition to alleging that Prudential's reimbursement determinations violated the Medicare Act, respondent also contended that Prudential's failure to reimburse it on the basis of its current prices, unaffected by the prevailing charge level during the preceding calendar year, violated the Due Process Clause of the Fifth Amendment. The language in 28 U.S.C. 1491 providing that the Court of Claims "shall have jurisdiction to render judgment upon any claim against the United States founded * * * upon the Constitution" has been construed to confer jurisdiction only where the particular constitutional provision relied upon can be read to mandate the payment of money damages by the United States for a violation. Although the Just Compensation Clause of the Fifth Amendment may be so read (*United States* v. *Testan, supra*, 424 U.S. at 401), the Due Process Clause of the Fifth Amendment may not. See *United States* v. *Hopkins, supra*, 427 U.S. at 130. The Court of Claims likewise has held that it does not have jurisdiction over claims founded upon the Due Process Clause where, as here, there is no jurisdiction over claims founded upon the particular statute involved. See *Alabama Hospital Ass'n.* v. *United States, supra*, slip op. 5; *Gordon* v. *United States*, No. 310-79T (May 6, 1981), slip op. 2 n.2; *Carruth* v. *United States*, 627 F.2d 1068, 1081 (Ct. Cl. 1980). The Court of Claims therefore was without jurisdiction to entertain respondent's constitutional claim as well. There is no occasion in this case to consider whether the district courts might have jurisdiction over constitutional challenges to the Medicare Act, particularly in view of the fact that the Court of Claims found respondent's constitutional arguments to be insubstantial in any event.

CONCLUSION

The judgment of the Court of Claims should be reversed.

Respectfully submitted.

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